



2100 New Bern Ave,  
Raleigh, NC 27610  
P. 855-326-9112 / F. 855-326-9114

# Hepatitis C

Date: \_\_\_\_\_ Needs by date: \_\_\_\_\_ Ship to:  Patient  Office 1st dose  Office All doses

Prescriber information	
Prescriber:	NPI:
Supervising physician:	NPI:
Address:	
Phone:	Fax:
Office contact:	

Patient information			
Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight:	Height:	Allergies:	
Primary language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		Needs interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Please include copies of the patient's insurance card or local pharmacy information.**

Medical information			
Diagnosis/ICD-10: <input type="checkbox"/> B18.2 Chronic Hepatitis C <input type="checkbox"/> Other: _____	ICD-10: _____	Co-infected?: <input type="checkbox"/> B20 HIV <input type="checkbox"/> Other: _____	
Genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	Viral Load: _____	Date Measured: _____	
Treatment status: <input type="checkbox"/> Naïve <input type="checkbox"/> Relapse <input type="checkbox"/> Non-responder <input type="checkbox"/> Partial responder	Previous therapy: _____		
Fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4	Cirrhosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Child-Pugh: _____	<input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated

Prescription information			Quantity	Duration	Refills
<input type="checkbox"/> Eplusa (sofosbuvir/velpatasvir)	400mg/100mg	Take one tablet by mouth daily with or without food.	28 day supply	___ weeks	___
<input type="checkbox"/> Harvoni (ledipasvir/sofosbuvir)	90mg/400mg	Take one tablet by mouth daily with or without food.	28 day supply	___ weeks	___
<input type="checkbox"/> Mavyret (glecaprevir/pibrentasvir)	100mg/400mg	Take three tablets by mouth daily with food.	28 day supply	___ weeks	___
<input type="checkbox"/> Vosevi (sofosbuvir/velpatasvir/ voxilaprevir)	400mg/100mg/100mg	Take one tablet by mouth daily with food.	28 day supply	___ weeks	___
<input type="checkbox"/> Zepatier (elbasvir/grazoprevir)	50mg/100mg	Take one tablet by mouth daily with or without food.	28 day supply	___ weeks	___
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg capsules <input type="checkbox"/> 200mg tablets	Take ___mg by mouth every morning, ___mg by mouth every evening	28 day supply	___ weeks	___

**Please include copies of the patient's most recent chart notes as well as results of any lab work (HCV Viral Load, HCV Genotyping, Fibrosis Score.) For NC Medicaid patients, please include a completed Beneficiary Readiness Evaluation form.**

## PHYSICIAN SIGNATURE REQUIRED

By signing below I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

**Stamp signature not allowed, physician attests this is his/her legal signature.**

\_\_\_\_\_ **Dispense as Written / Brand Medically Necessary**

\_\_\_\_\_ **Substitution allowed**

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